PCV118

IMPACT OF MEDICAID DISCONTINUITY ON HEALTH CARE RESOURCE UTILIZATION AMONG NON-ELDERLY ADULTS WITH CARDIOVASCULAR DISEASE

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OBJECTIVES: Medicaid coverage among non-elderly adults is often characterized by drop-outs and churning – entering and exiting Medicaid – over short durations. Little is known about the impact of such disruptions in Medicaid coverage on health care resources utilization and adherence to cardiovascular and lipid-lowering medications among enrollees with cardiovascular disease (CVD). **METHODS:** This was a retrospective, repeated cross-sectional study design employing data from 2002-2011 Medical Expenditure Panel Survey. Study sample included adults aged 18-64 years diagnosed with ≥1 CVD or associated comorbidity who reported having Medicaid coverage any time during survey year. Individuals with CVD having continuous, full-year Medicaid coverage (N=1,624) were compared to those with <12 months of coverage (N=3,394). Medication adherence was calculated as proportion of days covered by refills of any CVD medication class examined during the reference period, capped at 1, and analyzed using ordinary least squares regression and multivariate logistic regression. Utilization of 5 CVD-specific health care resources – inpatient, emergency (ER), outpatient, and office-based physician visits, and prescription medications – were estimated using zero-inflated negative binomial models controlling for sociodemographic, health status, disease burden, and Medicaid eligibility covariates, and year fixed effects. **RESULTS:** Older age, White race, higher income, intermittent employment, any private insurance were significant predictors of Medicaid discontinuity (P<0.05). Individuals experiencing discontinuity in Medicaid coverage were predicted to have 0.03 more inpatient (P<0.01), 0.03 more ER (P<0.001), and 0.24 less office-based physician visits (P<0.05), and 0.02 more prescription medications (P<0.05), all other things being equal. Medication adherence was not significantly different between the two groups, nor was it a significant predictor in most outcome models. **CONCLUSIONS:** Individuals with CVD having discontinuous Medicaid coverage had higher hospital, and lower primary care utilization than their counterparts with continuous Medicaid coverage. Medicaid programs will greatly benefit from implementing provisions that mitigate coverage instability and associated disruptions in continuity of care.

PCV119

EVALUATING THE OUTCOMES OF A DIABETES TREATMENT MANAGEMENT PROGRAM TARGETING APPROPRIATE ANTI-HYPERTENSIVE TREATMENT FOR ADULTS WITH DIABETES FOR DUAL AND NON-DUAL ELIGIBLE MEDICARE ADVANTAGE BENEFICIARIES

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OBJECTIVES: Diabetic nephropathy is the leading cause of chronic kidney disease in the United States and is associated with increased mortality. A quality measure that contributes to a CMS Star Rating is that patients with hypertension and diabetes receive a renin-angiotensin system (RAS) inhibitor. The objective of this study was to compare the impact of a Diabetes Treatment Management (DTM) Program, aimed to improve the compliance of appropriate RAS inhibitors for diabetic patients, between dual eligible (DE) and non-DE Medicare Advantage beneficiaries. **METHODS:** This was a retrospective study of pharmacy claims data among Medicare Advantage beneficiaries > 18 years of age in 2014. Members with one diabetic medication claim and one anti-hypertensive medication (calcium channel blockers or beta blockers) claim were included. The DTM program alerted the prescribing provider via fax to add a CMS recommended RAS inhibitor, if appropriate. Intervention success was defined when a recommended anti-hypertensive medication (renin angiotensin system antagonist, angiotensin converting enzyme, angiotensin receptor blocker, or direct renin inhibitor) was subsequently filled by the targeted member. Comparisons between groups were performed using the $\chi 2$ test. **RESULTS:** This data represents 1,037,543 non-DE and 195,413 DE Medicare Advantage beneficiaries. A total of 32,154 members were eligible for the DTM program. Of these, 26,896 (84%) were among non-DE and 5,258 (16%) were among DE Medicare beneficiaries. The DTM program was successful in 26% of the overall population. The success rate was 27% (7,177/26,896) among non-DE compared to 23% (1,211/5,258) among DE Medicare beneficiaries receiving the intervention (p<0.0001). **CONCLUSIONS:** The DTM program was more successful in the non-DE than in the DE Medicare Advantage population. However, further research is needed to understand the factors behind the difference in success for these populations.

PCV120

THE IMPACT OF DIFFERENT TYPES OF HEALTH INSURANCE ON THE HOSPITALIZATION SERVICES UTILIZATION OF PATIENTS WITH HEMORRHAGIC STROKE IN CHINA

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OBJECTIVES: The study aimed to compare the direct medical cost difference of hemorrhagic stroke inpatients with different types of health insurance from 2010 to 2012 in China. **METHODS:** A nationwide, cross-sectional sampling of hemorrhagic stroke inpatients with disease code ICD-10 (I60,I61,I62) with basic medical insurance scheme for employees (BMISE) and basic medical insurance scheme for urban residents (BMISUR) was extracted from the China Health Insurance Research Association claim database. A retrospective analysis was adopted. **RESULTS:** The inpatients number of BMISE was 5321,the inpatients number of BMISUR was 1510. The average age was 63.08 and 62.34 years, respectively. Patients with BMISE went to third-level hospitals, second-level hospitals and under second-level hospitals accounted for 57.01%, 33.71% and 9.27%; but for BMISUR, the percentage of distribution was 48.94%, 37.76% and 11.31%. From 2010 to 2012, the average hospitalization expenses of each visit with BMISE was 25575.34, 24219.22 and 26889.57 yuan; For BMISUR, the expenses of each visit was 21211.57, 18999.53 and 19088.96 yuan. Reimbursement by BMISE in 2010, 2011 and 2012 was 71.01%, 74.12% and 68.25%; while the reimbursement by BMISUR was 45.95%, 53.49% and 51.16%. **CONCLUSIONS:** The insurance level difference between two health insurance schemes influences the treatment regimens and benefits received by patients. People prefer to go to third-level hospitals, but people with BMISE has higher proportion than people with BMISUR, about 10%. For the people with BMISUR, the out-of-pocket spending was 50% of total expenses, needing to raise reimbursement rate, setting up differentiated reimbursement for different income level groups. From 2011 to 2012, the reimbursement rate declined slowly, we need to study the cause in the future.

PCV121

THE EXPANSION OF STROKE CENTERS AND THE REDUCTION OF IN-HOSPITAL MORTALITY OF ISCHECHEMIC STROKE PATIENTS IN ALBERTA

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OBJECTIVES: According to Canada, US and European guidelines and the Helsingborg Declaration, all eligible stroke patients should receive care in specialized stroke centers. During the last decade, partly due to the Alberta Provincial Stroke Strategy (APSS), 16 stroke centers were established in Alberta. This study examined the effect of admission to stroke centers on mortality for patients with ischemic stroke, compared with admission to non-stroke centers. **METHODS:** The study population was identified from the Discharge Abstract Database (DAD) from the province of Alberta, Canada. We included stoke patients with most response diagnostic code I63 (ICD10) with a first admission to acute care hospitals between April 1st 2004 and March 31st 2011. Disease specific co-morbidities were adapted from the literature review, including secondary diagnoses in the DAD. We utilized the triage information from National Ambulatory Care Report System (NACRS) as the proxy of disease severity. The average marginal effect of stroke center on the 30-days in-hospital mortality was estimated in a bivariate probit model, using differential distance to hospitals as an instrumental variable to correct potential pre-hospital selection bias, adjusting for age, sex, co-morbidities, and disease severity. **RESULTS:** Among 9152 patients, 6405 (70%) were admitted to stroke centers (n=16) and 2747 (30%) to non-stroke centers. The overall unadjusted 30-day all-cause mortality rate was 9.8% for patients first admitted to stroke centers and 11.1% for patients admitted to non-designated hospitals. Adjusting patient characteristics and other factors, we found first admission to a stroke center was associated with a 6.4% (95%CI: -1.2%, -11.5%) absolute reduction in 30-day all-cause in-hospital mortality compared to non-stroke centers. **CONCLUSIONS:** In an observational study, we provided new evidence to support the role of stroke center on the reduction in mortality in a universal publicly funded health care system.

PCV122

THE IMPACT OF STROKE CENTERS ON THE LENGTH OF STAY AMONG ISCHECHEMIC STROKE PATIENTS IN ALBERTA

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OBJECTIVES: Although previous studies have shown that stroke centers reduce mortality in patients with ischemic stroke, the association between stroke centers and reduction in length of stay (LOS) in hospital has not been demonstrated. We sought to evaluate the impact of stroke centres as designated by the Alberta Provincial Stroke Strategy (APSS) in Alberta on the LOS of acute ischemic stroke patients. **METHODS:** We compared the actual LOS during the first episode of hospitalization for patients with acute ischemic stroke admitted first to designated stroke centers or non-stroke centers between April 1st 2004 and March 31st 2011 using the Alberta Hospital Discharge Abstracts Database. Using propensity score methods, we applied a log linear regression model to estimate the average change in LOS for all ischemic patients and the change for the patients admitted to the stroke centers, adjusting for age, sex, co-morbidities, disease severity, discharge type and being in the alternate level of care. **RESULTS:** Among 9,092 patients, 6,360 (70%) were admitted to stroke centers. The prolonged hospital stay with alternate level of care designation had occurred in 1,572 (17.3%) of patients. The number of patients discharged to home, home with support or other health care facility, or died were 3,767(41.4%) 4,159(45.7%), and 1,166 (12.8%), respectively. The average unadjusted LOS was 21.3 (SD=33.9) days for patients admitted to stroke centers and 24.8 (SD=37.5) days for patients admitted to non-stroke centers. Adjusting for the patient characteristics and other factors, we estimated that the average LOS was reduced by 6.5% (95%CI: -12.3%, -0.6%) for patients first admitted to stroke centers compared with non-stroke centers. **CONCLUSIONS:** The study shows that in patients with acute ischemic stroke, first admission to stroke centers had significantly reduced LOS compared with non-stroke centers in Alberta by about 1.4 days.

PCV123

PHARMACOECONOMICS RESEARCH ON DIABETES AND HYPERTENSION IN INDIA: A STUDY BASED ON PUBMED DATABASE

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